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No. 88-1808

In the Supreme Court of the United States

OCTOBER TERM, 1989

RICHARD D. BUSHMAN AND
ROBERT L. BUSHMAN, PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

KENNETH W. STARR
Solicitor General
STUART E. SCHIFFER
Acting Assistant Attorney General
JOHN F. CORDES
KATHERINE S. GRUENHECK
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 633-2217

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QUESTION PRESENTED

Whether the appeals court erred in holding that it lacked jurisdiction over a claim that the Secretary of Health and Human Services violated petitioners' due process rights by failing to give adequate notice of the requirements for filing a valid Medicare claim.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A6) is reported at 862 F.2d 1327. The memorandum opinion of the district court (Pet. App. A9-A13) is reported at 661 F. Supp. 266.

JURISDICTION

The judgment of the court of appeals was entered on December 9, 1988. A petition for rehearing was denied on January 18, 1989 (Pet. App. A7). The petition for a writ of certiorari was filed on April 18, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Medicare Part B is a voluntary supplemental insurance program that provides reimbursement for physicians' and various related ancillary services (42 U.S.C. 1395*l*). See Medicare Act, 42 U.S.C. 1395j-1395w (1982 & Supp. IV 1986). Private insurance carriers administer Part B benefits under contracts with the Secretary of Health and Human Services (HHS) (42 U.S.C. 1395u(a)(1)). The carrier reimburses Medicare patients, or their providers as assignees, for 80% of the "reasonable charges" for reimbursable services, as determined by the carrier in accordance with the Medicare statute and regulations promulgated by the Secretary (42 U.S.C. 1395*l*).

The Medicare statute provides for "a fair hearing by the carrier" if a dispute arises concerning the amount of reimbursement due a Medicare provider (42 U.S.C. 1395u(b)(3)(C)). During the period pertinent to this dispute the statute did not provide for administrative or judicial review of the carrier's determination as to amounts of reimbursement payable under Medicare Part B. See 42 U.S.C. 1395ff.

Limited coverage is available for services provided by podiatrists to Medicare beneficiaries enrolled under Part B. Section 4120.1(3) of the *Medicare Carriers Manual* (1978) [hereinafter *Medicare Carriers Manual*], in the version that applies to this case (see App., *infra*, 1a-2a), excludes Medicare coverage for routine foot care provided to healthy individuals, but permits "[p]ayment * * * for routine-type foot care * * * when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous." [1]

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[1] Section 4120.1(3)(a) also provides that (App., *infra*, 2a):

> Claims for such routine services would show in item 7D of the SSA-1490 the complicating systemic disease. Where these services

2. Richard and Robert Bushman are podiatrists who administered foot care to Part B Medicare beneficiaries between October 1979 and October 1981. Patients assigned their claims for reimbursement to the Bushmans pursuant to 42 U.S.C. 1395u(b)(3)(B)(ii) and the Bushmans, in turn, filed requests for payment with the Medicare carrier authorized to make such payments. The carrier paid all of the claims in full. After a review by the carrier of a statistically valid sample of the Bushmans' claims, however, it was determined that there was insufficient documentation of the medical necessity of the treatment administered on 251 claims. The carrier found that Richard Bushman had received $11,784.00 in overpayments and that Robert Bushman had received $9,139.20 in overpayments, and requested refunds (Pet. 2-3).

The Bushmans requested a hearing pursuant to 42 U.S.C. 1395u(b)(3)(C) and 42 C.F.R. 405.801 *et seq.*, on the carrier's initial determination. Prior to the hearing, the hearing officer identified the 251 disputed claims, informed the Bushmans that the overpayment determination had been based on inadequate documentation of the patients' medical condition, and provided a copy of the regulations that governed the decision, including Section 4120.1(3)(a) of the *Medicare Carriers Manual*. See Gov't C.A. Br. 9-10; Pet. App. A12.

At the hearing, the Bushmans were afforded an opportunity to substantiate their claims. They introduced testimony by ~~four~~ physicians who had examined the patients, or the records of patients, for whom claims had been re-

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were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

jected, and they submitted charts on 35 of the patients. See App., *infra,* at 4a-5a (August 7, 1984 letter reaffirming Medicare Carrier Fair Hearing decision [hereinafter August 7 letter]). On the basis of the evidence submitted by the Bushmans at the hearing, the hearing officer determined that 42 of the Bushmans' claims were properly paid and that the balance of the claims were improperly paid (Pet. App. A11). Accordingly, the hearing officer reduced the overpayment determinations to $9,047.04 and $7,484.00, respectively (*ibid.*).

The Bushmans sought review of the hearing officer's decision from the Health Care Finance Administration (HCFA) of the Department of Health and Human Services. HCFA requested the carrier either to reopen the case or to reaffirm its decision (Pet. App. A3). The carrier reaffirmed its decision (*ibid.*), which became the final decision of the Secretary. See 42 C.F.R. 405.835. Medicare demanded refunds of the overpayments, and the Bushmans refused (Pet. App. A3).

3. The United States brought this action against the Bushmans to collect the Medicare overpayments. The Bushmans defended the action before the district court by claiming that the unfair manner in which their claims were evaluated by the hearing officer, and the inadequate notice they received of the basis for her decision, denied them due process of law (Pet. App. A12). Relying on *United States* v. *Erika, Inc.*, 456 U.S. 201, 203 (1981), the district court held that it did not have jurisdiction to "consider any contention that the carrier erred in determining that the Bushmans received overpayments" (Pet. App. A12), but that it did have jurisdiction over the claim "that the manner in which the carrier made this determination violated their federal constitutional due process rights" (*ibid.* (citations omitted)). With respect to the latter claim, the court

concluded that there was no due process violation because "defendants did not prove that they did not have adequate notice of the grounds on which [the hearing examiner] would ultimately base [her] decision" (*ibid.*). Judgment was entered against the Bushmans for the Medicare overpayments of Part B benefits as determined in the carrier's final decision (Pet. App. A13).

3. The Eighth Circuit affirmed the judgment against the Bushmans (Pet. App. A1-A6), but disagreed with the district court concerning jurisdiction over the Bushmans' due process claim. The court took note of the Bushmans' argument that "they are not seeking review of the amount" of benefits, but "are seeking their constitutionally guaranteed right to a fair hearing before an unbiased hearing officer" (Pet. App. A5). The court nevertheless concluded that review of their claims was unavailable under Section 1395ff of the Medicare Act, explaining that "[e]ven though the Bushmans couch their claims in constitutional language" (Pet. App. A5),

> [t]he essence of the Bushmans' due process claim is that they received an unfair hearing. * * * [T]hey seek our review of the validity of their claims by asserting that the result reached was error because of [the hearing officer's] alleged bias and incompetence. At bottom, this is simply a claim that the Bushmans were entitled to the Medicare Part B benefits they received, a claim not cognizable by this court. *Erika*, 456 U.S. at 206-08.

(Pet. App. A5-A6). The court added that, "to the extent that [the] claim does implicate the due process clause, it is so inextricably intertwined with the Bushmans' claims for benefits that it is unreviewable by this court" (Pet. App. A6), citing *Heckler* v. *Ringer*, 466 U.S. 602, 614 (1984), and *Hatcher* v. *Heckler*, 772 F.2d 427, 429-431 (8th Cir. 1985).

ARGUMENT

Petitioners seek review from this Court on the narrow question whether they were denied due process by the Secretary's procedures for evaluating their claims for reimbursement under Medicare Part B. In particular, petitioners argue (Pet. 10) that the claim form prepared by the Medicare program (HCFA-1490) did not track the language of the *Medicare Carriers Manual* provision excluding coverage for routine foot care, Section 4120.1(3)(a), and therefore petitioners were deprived of notice of the specific information they were required to supply in support of their claims.[2] Pet. 11. The judgment of the court of appeals rejecting petitioners' claims is correct. That decision is consistent with decisions of this Court and other courts of appeals. Additionally, the specific question presented here is of limited importance. Accordingly, this Court's review is not warranted.

1. Petitioners' sole contention[3] in this Court (Pet. 7-8) is that one of their due process claims – that the Secretary's disallowance of their Medicare Part B claims is unfair because the Medicare forms on which petitioners submitted their claims failed to inform them of the requirements for filing a valid Medicare claim – is collateral to the carrier's determination on the merits, and therefore is reviewable

[2] As Section 4120.1(3)(a) of the *Medicare Carriers Manual* (see note 1, *supra*, and App., *infra*, 2a) makes clear, at a minimum, a physician must produce evidence of a systemic disease before Medicare will cover routine foot care. Additionally, a podiatrist must name the referring physician who diagnosed the "complicating condition" and the approximate date the beneficiary was last seen by such physician.

[3] Petitioners apparently abandon their additional due process argument, which was the focus of the court of appeals' decision, that the hearing examiner was biased and conducted an unfair review of the evidence. The court of appeals correctly viewed this claim as intertwined with the merits and plainly unreviewable (Pet. App. A4-A6).

in court under *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). The court of appeals did not address this claim as such, perhaps because the focus of petitioners' due process challenge was elsewhere.[4] In any event, petitioners' constitutional claim of inadequate notice is entirely lacking in substance and "obviously without merit." See *Bowen* v. *Michigan Academy*, 476 U.S. at 681 n. 12 (citing *Hagans* v. *Lavine*, 415 U.S. 528, 537 (1974)). The court therefore properly declined to take jurisdiction over their claim.

a. Petitioners' contention that the Secretary failed to provide them with fair notice of the requirements for filing a valid Medicare claim is unsupported by the record in this case. The *Medicare Carriers Manual* (see note 1, *supra*, and App., *infra*, 1a-2a) clearly indicates that routine foot care is not covered under Medicare Part B unless the beneficiary to whom services are provided suffers from a systemic disease of sufficient severity. The regulations also state that the foot care provider must name the referring

[4] At only one point in their brief before the court of appeals did petitioners complain that "[t]here is *no* place or box for the podiatrist to insert the name of the referring [physician]" on the Medicare claim form, and that they were not aware that they were required to supply the name. See Pet. C.A. Br. 25. They went on to state that "the failure of Appellants to follow these phantom regulations [requiring listing of the physician's name and date last seen] is the basis of [the hearing officer's] negative decision." *Ibid.* Based on this statement, the court of appeals may well have understood petitioners to be arguing that the carrier's *application* in this case of the requirement that they list the physicians' names on the original form, despite the absence of a "box" in which to list them, violated their due process rights. As a challenge to the carrier's application of the Secretary's regulations, the claim would appear to be unreviewable under *United States* v. *Erika, Inc.*, 456 U.S. at 203.

physician who diagnosed the "complicating condition" and the approximate date the beneficiary was last seen by the physician. Petitioners nowhere substantiate their assertion that they were "unable to get a copy of the carrier's manual" (Pet. 8). On the contrary, prior to their hearing before the Medicare carrier, petitioners were furnished with a copy of all law applicable to their claims, including Section 4120.1(3)(a) of the *Medicare Carriers Manual.* Petitioners were also provided with an opportunity to submit evidence in support of their claims to the hearing officer. Petitioners in fact availed themselves of this opportunity and introduced additional evidence with respect to a fraction of their claims; as to those claims, the carrier determined the payments were proper. The carrier was correct to apply the *Medicare Carriers Manual* Section 4120.1(3)(a) to deny the claims for which there was inadequate documentation of the treated beneficiaries' medical condition, and the carrier's determination may not be judicially reviewed. *United States* v. *Erika, supra.*

b. Petitioners' complaint (Pet. 10-11) about the absence of a "box" on the Medicare claim form for the listing of a treating physician and date of treatment is beside the point. The record in this case clearly indicates that petitioners' failure to list treating physicians' names on the original claim forms had nothing to do with the carriers' final decision to disallow their Medicare claims. Petitioners were provided ample opportunity to correct any omission of physicians' names from their original claim forms, and the rejection of petitioners' claims was ultimately based on their failure adequately to substantiate the beneficiaries' medical condition, as required by Section 4120.1(3)(a) of the *Medicare Carriers Manual.* See App., *infra,* 4a-6a (August 7 letter). Petitioners do not challenge this requirement, and the record unequivocally shows that they had notice of it.

Because petitioners' initial omission of the names of treating physicians did not affect the ultimate disposition of their claims for reimbursement, petitioners' due process rights could not possibly have been violated by the Secretary's failure to provide a box on the Medicare claim forms for listing the treating physicians' names. In short, the record makes plain that the procedural defect of which petitioners complain had no effect on the disposition of their claims. Therefore, a due process claim based on the inadequacy of the notice provided by the Medicare claim forms is too insubstantial to merit review.

2. Petitioners concede (Pet. 13) that their "claim is probably *sui generis*" and that resolution of the question presented would probably affect only a very small number of cases. Petitioners also note that, in 1986, Congress amended 42 U.S.C. 1395ff to permit judicial review of certain Medicare Part B amount determinations for services furnished after January 1, 1987 (Pet. 13). This amendment deprives this case of ongoing significance and further undermines petitioners' claim that it presents an issue that warrants this Court's consideration.[5]

[5] See Gov't Br. in Opp., *Kuritzky* v. *Blue Shield*, 850 F.2d 126 (2d Cir. 1988), cert. denied, No. 88-685 (Jan. 9, 1989), slip op. 2 n.1; Gov't Br. in Opp., *Association of Seat Lift Manufacturers* v. *Bowen*, 858 F.2d 308 (6th Cir. 1988), cert. denied, No. 88-1044 (Mar. 20, 1989) slip op. 6 n.7.

CONCLUSION

The petition for a writ of certiorari should be denied.
Respectfully submitted.

KENNETH W. STARR
Solicitor General
STUART E. SCHIFFER
Acting Assistant Attorney General
JOHN F. CORDES
KATHERINE S. GRUENHECK
Attorneys

JULY 1989

4120. FOOT CARE

4120.1 *Application of Foot Care Exclusions to Physicians' Services.* – The exclusion of foot care is determined by the nature of the service (§ 2323). Thus, reimbursement for an excluded service should be denied whether performed by a podiatrist, osteopath, or a doctor of medicine, and without regard to the difficulty or complexity of the procedure.

When an itemized bill shows both covered services and noncovered services not integrally related to the covered service, the portion of charges attributable to the noncovered services should be denied. (For example, if an itemized bill shows surgery for an ingrown toenail and also removal of calluses not necessary for the performance of toe surgery, any additional charge attributable to removal of the calluses should be denied.)

In reviewing claims involving foot care, the carrier should be alert to the following exceptional situations:

1. Payment may be made for incidental noncovered services performed as a necessary and integral part of, and secondary to, a covered procedure. (For example, if trimming of toenails is required for application of a cast to a fractured foot, the carrier need not allocate and deny a portion of the charge for the trimming of the nails. However, a separately itemized charge for such excluded service should be disallowed. When the primary procedure is covered the administration of anesthesia necessary for the performance of such procedure is also covered.

2. Payment may be made for *initial* diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.

3. Payment may be made for routine-type foot care such as cutting or removal of corns, warts, calluses, or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous (§ 2323C).

a. Claims for such routine services would show in item 7D of the SSA-1490 the complicating systemic disease. Where these services were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

* * * * *

MEDICARE PART B/GENERAL AMERICAN
P.O. Box 505
St. Louis, MO 63166
Phone: (314) 843-8700

August 7, 1984

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Financial Operations
Department of Health and Human Services
HCFA, Region VII
Federal Office Building
601 East 12th Street
Kansas City, MO 64106

Dear Mr. Blake:

In response to your letter of July 9, 1984, I wish to reaffirm the decision made in the Medicare Fair Hearing involving Drs. Robert and Richard Bushman. I welcome the opportunity to clarify my position as the hearing office, since it is apparent that the Bushman brothers do not understand the basis of the decision.

Before the hearing itself, I met with Mr. Marglous, the Bushmans' counsel, and provided him with pertinent regulations concerning podiatry services. At that time, we also discussed the sampling procedure used by our program control department. Mr. Marglous was given the opportunity to review the file in its entirety. I explained that at the hearing, my role was to receive any evidence which might have bearing on the matter of the overpayment, that witnesses could be presented, and testimony received. Upon his review of the hearing file, Mr. Marglous requested that the Medicare podiatry consultant be present at the time of the hearing.

On March 19, 1982, the hearing was conducted. The Bushmans' counsel began by questioning Dr. Seiler, the carrier's podiatry consultant. It was apparent from the line of questioning that Mr. Marglous attached a great deal of importance to a document in the hearing file, a letter from Dr. Seiler to the Program Control Department. The letter referred to Dr. Seiler's assessment of a sample of claims from the Bushmans which he had been asked to review. In the course of the hearing, that sample was mistakenly said to be the same sample upon which the overpayment determination was based. Upon questioning, I indicated that I believed the sample to be the same, since no other claims were included in the file. Later events were to reveal, however, that the claims in the hearing file were not those previously reviewed by Dr. Seiler. The sample he actually reviewed was not included in, or part of, the overpayment determinations at issue.

Neither Mr. Marglous nor his clients, the Bushmans, appeared to understand the role of Dr. Seiler in this matter. He was present at the hearing to provide technical and professional assistance to me, the hearing officer, and because his presence was requested by the Bushmans. From the line of questioning, it seemed that Dr. Seiler was seen as the instigator of the Program Integrity case against the Bushmans.

During the hearing, a number of photographic slides were presented and reviewed as additional evidence. In some cases, Dr. Seiler's opinion concerning this evidence influenced my decision to reverse the carrier's determination on particular claims.

The witness Ayoboola Brimmo, M.D. indicated that he had reviewed medical records for beneficiaries treated by the Bushmans. Dr. Brimmo did not personally examine

the patients. I was not able to accept his generalized remarks that elderly patients have compromised vascular status as evidence which met the criteria stated in the Medicare Carrier's Manual.

A letter from Bayard C. Vermilyea, D.O. was presented in evidence. The letter indicated a systemic connotation associated with arteriosclerotic diseases. This letter could not provide a basis for the criteria required by Medicare regulations.

A letter from K. L. Bradshaw, D.P.M. recorded his findings upon examination of 50 nursing home patients treated by the Bushmans. This testimony did not detail any specific findings to support his diagnosis of peripheral vascular disease of the severity addressed by Medicare regulations. He further described peripheral vascular disease as a normal consequence of aging.

A total of 35 nursing home records were presented by the Bushmans as evidence of meeting Medicare's criteria for coverage of routine foot care. This evidence provided me the substantive basis for the majority of my reversals of the carrier's determination.

The Bushmans and their counsel apparently have failed to understand the intention and detail of Medicare's regulations concerning podiatry coverage for routine foot care. The law does not allow the carrier or a hearing officer to accept non-documented generalizations concerning diagnoses.

To conclude, as hearing officer, I found a large portion of the evidence presented to be insufficient under Medicare regulations to warrant coverage of the services performed by the Bushmans.

I would like to add that in the course of the hearing and subsequent proceedings, the issue should have become clear to the Bushmans. That is, the responsibility to document or substantiate services billed to Medicare lies with the provider of those services. Information required on the claim is the responsibility of the provider. The Bushmans were asked for the names of referring physicians, or for diagnoses substantiated by specific symptoms or findings. It should be noted that there was a reduction in the overpayment amount where such evidence was presented. Conversely, where such evidence was not presented, the overpayments were affirmed and remain so to this writing.

Sincerely yours,

/s/ Linda Benso
LINDA BENSO
Medicare Hearing Officer

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